CONSENT FOR TREATMENT

COOSA VALLEY MEDICAL CENTER
315 W. HICKORY STREET
SYLACAUGA, AL 35150

CONSENT OF HOSPITAL SERVICES: Consent is given to Sylacauga Health Care Authority, d/b/a Coosa Valley Medical Center, Horizon Imaging P.C., Sylacauga Anesthesia LLC, the patient's physician, Coosa Valley MRI LLC, and Pegasus Emergency Group Coosa Valley LLC, its contractors and its employees to provide hospital services and administer physican orders. Certain procedures may require separate consents. Physicians are responsible for explaining medical or surgical procedures, and patients may be called following their procedure for quality and continuum of care. The undersigned authorizes observers to be present during treatment/surgery for purposes of medical training and education.

PHYSICIANS: Physicians including, without limitation, Pegasus Emergency Group Coosa Valley LLC, Horizon Imaging P.C., Sylacauga Anesthesia LLC, Coosa Valley MRI LLC, and the patient's physician in our facilities. They are not employees or agents of Coosa Valley Medical Center.

I hereby consent to receiving auto-dialed and/or artificial or pre-recorded message calls to my cellular telephone and to any telephone number provided by me on this form from Coosa Valley Medical Center or its affiliates and their agents including without limitation, any account management companies and independent contractors including without limitation, any debt collectors.

____
Consent for treatment (by patient or authorized representative)

____
Date

____
Witness

CONDITIONS OF ADMISSION PRIVACY NOTICE AND FINANCIAL RESPONSIBILITY

COOSA VALLEY MEDICAL CENTER

PERSONAL VALUABLES: The Coosa Valley Medical Center is not responsible for money, jewelry, dentures, hearing aids, eye glasses, watches, credit cards, and such other items which are not deposited in the hospital safe.

AUTHORIZATION TO RELEASE INFORMATION: The undersigned authorizes the Coosa Valley Medical Center and any physician rendering service, for example, Horizon Imaging P.C., Pegasus Emergency Group Coosa Valley LLC, Coosa Valley MRI LLC, and Sylacauga Anesthesia LLC to release medical or other information about the patient which may be necessary for the completion of insurance claims, review of service, or receipt of benefits. Such information may include current medical records. The information may be released to third-party payors, including the third-party payor's agent and/or representative or anyone responsible for payment of hospital and/or physician charges.

PATIENT EDUCATION: Coosa Valley Medical Center is a smoke free facility. Smoking cessation information is provided to each patient on admission. The undersigned agrees that smoking cessation education has been received.

CONSENT TO PHOTOGRAPH: The undersigned authorizes CVMC to photograph, videos, digital or other images that may be recorded to document patient care, for medical staff education, research, legal or for use by a public agency. I waive all rights that I may have to any claim for payment, royalties, or other remuneration in connection with any exhibition of foregoing recordings. Any photograph, video, digital or other images are property of CVMC.

ASSIGNMENT OF BENEFITS: The undersigned assigns to and authorizes direct payments of benefits (including insurance benefits, otherwise payable with respect to the patient) to the Coosa Valley Medical Center, Pegasus Emergency Group Coosa Valley LLC, Horizon Imaging P.C., Sylacauga Anesthesia LLC, Coosa Valley MRI LLC and Physicians. The undersigned agrees to assist processing claims for benefits.

MEDICARE AUTHORIZATION: I certify the information given by me in applying for payment under Title XVII of Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and CMS or its Intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of the authorized benefits be made on my behalf to the Coosa Valley Medical Center, Pegasus Emergency Group Coosa Valley LLC, Horizon Imaging P.C., Sylacauga Anesthesia LLC, Coosa Valley MRI LLC or any physician rendering service during my treatment.

FINANCIAL RESPONSIBILITY: The undersigned agrees to pay for hospital services, accommodations and physician services rendered to patient and is hereby obligated to pay the accounts of the hospital. It is understood that in the event of obstetrics care the undersigned is obligated to pay the hospital account for mother and infant(s). It is understood and agreed that Coosa Valley Medical Center charges not paid may be placed with an attorney or collection agency. It is understood and agreed that reasonable cost of collection including attorneys fees, collection agency fees, and/or open account interest charges assessed are payable by the undersigned. To the extent not expressly prohibited by applicable law, the undersigned agrees to pay all hospital charges not paid in full to the hospital by a third-party payor. I understand that inpatients in a private room (patient requested or medically necessary) are charged per day over the semi-private room rate, which I agree to pay balance after deposit when I am discharged. The Coosa Valley Medical Center accepts cash, MasterCard, Visa, and Discover Card.

The undersigned is aware that in some cases the patient's hospital bill may not be covered in full by the insurance company. The undersigned is aware of the fact the (patient/responsible party/guarantor) are responsible for any balance insurance does not pay. This balance due may include provisions set by your insurance company such as: co-payments, deductibles, and "usual and customary" allowances. Co-payments and deductibles are due upon admission and must be paid prior to discharge.

I ACKNOWLEDGE THAT I HAVE READ THIS FORM AND UNDERSTAND ITS PURPOSE AND CONTENT

____

Guarantor (Agreement to Pay)

________________________________	________________________________
I have received the privacy notice	Refused the privacy notice
__________________________	________________________________

MRI SAFETY SCREENING FORM FOR PATIENTS

Contrast ______________________________

Lot # \ Exp. Date ______________________

GFR ________________________________

Please read and check YES or NO to the following questions:

☐ Yes ☐ No Brain aneurysm clip(s)
☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Electronic implant or device
☐ Yes ☐ No Magnetically-activated implant or device
☐ Yes ☐ No LINX Reflux Management System
☐ Yes ☐ No Neurostimulation system
☐ Yes ☐ No Spinal cord stimulator
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Bone growth/bone fusion stimulator
☐ Yes ☐ No Cochlear, otologic, or other ear implant
☐ Yes ☐ No Insulin or other infusion pump
☐ Yes ☐ No Implanted drug infusion device
☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Resolution clip in GI Tract
☐ Yes ☐ No Endoscopic capsule camera
☐ Yes ☐ No Pregnant or nursing an infant
☐ Yes ☐ No Metallic stent, filter, or coil
☐ Yes ☐ No Tissue expander (e.g., breast)

☐ Yes ☐ No Shunt (spinal or intraventricular)
☐ Yes ☐ No Vascular access port and/or catheter
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No Injury to eye involving metallic slivers or foreign body
☐ Yes ☐ No Metallic fragment inside body (shrapnel, bullet, BB. etc.)
☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Artificial or prosthetic limb
☐ Yes ☐ No Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Joint replacement (hip, knee, etc.)
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes ☐ No IUD, diaphragm, or pessary
☐ Yes ☐ No Dentures or partial plates
☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid (remove before entering MR system room)
☐ Yes ☐ No Other implant______________________________
☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Claustrophobia

NOTE: You will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

VERY IMPORTANT. PLEASE READ and SIGN.

CONTRAINDICATIONS: Since MRI uses a strong electromagnetic field, **you cannot undergo this procedure if you have any of the following:** Cardiac pacemaker; cochlear implant; neurostimulators; metal fragments in the eye; implanted drug infusion pump (Medtronics OK); magnetically activated implant or device; or certain types of aneurysm clips implanted in the brain. ***Please inform us if you have any other implants not mentioned***

PREGNANCY: Currently there is no known evidence through the FDA and the American College of Radiology of an MRI, with or without contrast, having adverse effects on the fetus. However, it is the policy of this facility to proceed with caution. Please inform a member of our staff if you are pregnant or if you think you might be pregnant.

CONTRAST: Your Doctor may have requested that your exam be performed with intravenous contrast media if necessary during the MRI exam. Our contrast media of choice is OptiMARK®, Magnevist® and Multihance®. OptiMARK®, Magnevist® and Multihance® injections are FDA approved and indicated for use with MRI examinations. Although OptiMARK®, Magnevist® and Multihance® are very safe and allergic reactions are extremely rare, the possibility of an allergic reaction does exist. In addition, related complications such as pain or swelling at the sight of injection or phlebitis, although rare, are possible. The purpose, benefits and complications of the contrast procedure will be explained to your satisfaction before any injection takes place.

****If you are receiving an MRI that requires contrast and you are currently being treated, or have been treated, for renal insufficiency or renal dysfunction due to hepato-renal syndrome or in the perioperative liver transplantation period, please see a member of our staff before beginning your exam.**

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedures that I am about to undergo.

_______________________________________ _______________________

PATIENT SIGNATURE/ GUARDIAN'S SIGNATURE (IF PT. IS A MINOR) **DATE**

_______________________________________ _______________________

FORM INFORMATION REVIEWED BY **DATE**

PATIENT HEALTH HISTORY

Please read and answer the following questions:

1. Height? ____________________ Weight? ______________________

2. Do you have a personal history of:

☐ Yes	☐ No	Heart disease?	☐ Yes	☐ No	Diabetes?
☐ Yes	☐ No	Kidney disease?	☐ Yes	☐ No	High Blood Pressure?
☐ Yes	☐ No	Liver disease?	☐ Yes	☐ No	Sickle Cell Anemia?
☐ Yes	☐ No	Cancer?	☐ Yes	☐ No	Seizures?
☐ Yes	☐ No	Myasthenia Gravis	☐ Yes	☐ No	Multiple Myeloma?
☐ Yes	☐ No	GERD (Gastroespohageal Reflux Disease)			

3. Do you have additional medical conditions not listed above? Please list: ____

____

4. Are you allergic to any medications and/or contrast dye? ☐ Yes ☐ No Please list:______________________________________

____

5. Have you ever had spine surgery? ☐ Yes ☐ No ☐ Cervical Year _________ ☐ Thoracic Year _________ ☐ Lumbar Year _________

6. Have you had other surgeries? ☐ Yes ☐ No Please list: ____

____

7. Are you currently taking any medications? ☐ Yes ☐ No Please list drug name, dosage and frequency or provide a pre-written list to be copied :

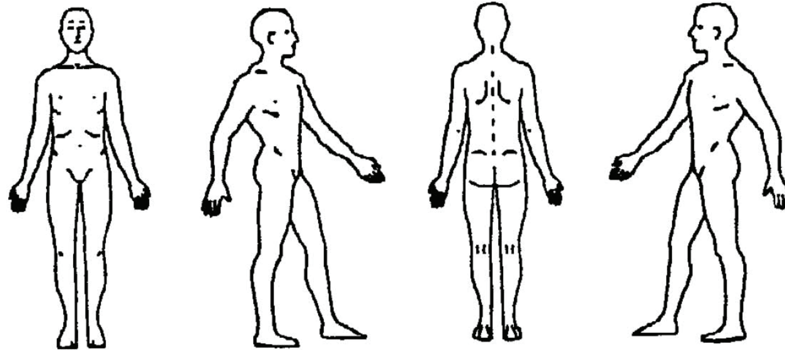
____

____

____

8. What is your chief complaint(s)? ____

On the diagram below, please "X" the area(s) that hurts and/or concerns you the most.



9. Please specify the cause of your symptoms and the date your symptoms began.

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I confirm that the information I provided is complete and accurate to the best of my knowledge.

____ ____________________

PATIENT SIGNATURE/PARENT OR GUARDIAN IF PATIENT IS A MINOR **DATE**

____ ____________________

FORM INFORMATION REVIEWED BY **DATE**

AUTHORIZATION TO USE, DISCLOSE OR RELEASE HEALTH INFORMATION

Any physician, staff, employee or representative of Coosa Valley MRI, LLC has my permission to discuss and/or release my account information and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons and/or organizations in order to facilitate and coordinate my care, treatment and payment.

Name	Relationship	Phone Number(s)

FOR THE PROTECTION OF YOUR PERSONAL HEALTH INFORMATION, WE WILL NEED PHOTO ID WHEN PICKING UP MEDICAL RECORDS.

I understand that authorizing the release of my information to the above individuals and/or organizations is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke this authorization by writing to Coosa Valley MRI, LLC or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals and/or organizations it may be subject to redisclosure by the individuals and/or organizations.

I release Coosa Valley MRI, LLC, its employees and agents from any liability in connection with the use or disclosure of the information and records released to any party pursuant to this Authorization.

Patient Signature:______________________________ Date:______________

A PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

Coosa Valley Medical Center's staff and doctors want you to enhance your health, dignity and wholeness. Because of our mission, we hereby adopt this Bill of Rights and Responsibilities.

You Have the Right to:

1. Be treated with respect, kindness, and dignity.
2. Proper treatment for your health condition no matter what your race, creed, gender, age, religion, language, culture, physical or mental disability, country of origin, or source of payment for your care.
3. Be told about your medical condition, treatment and outlook in terms that you can understand.
4. Make choices about your own care, including the right to request care, and the right to select a representative to be involved in care and the right to withdraw or deny these rights orally or in writing at any time.
5. Expect we will listen to and address your pain concerns.
6. Say no to care as allowed by law.
7. Have your family or your caregiver notified of your admission to the hospital.
8. Have your personal physician notified of your admission to the hospital.
9. Make an advance directive, including a living will and/or power of attorney for health care. The hospital will ask you about this when you are admitted. You also have the right for your caregivers to follow your advanced directive.
10. Privacy of your medical records and details about your care.
11. Look at your medical records.
12. Personal privacy.
13. Safety while in the hospital and facts about the use of safety items, such as restraints.
14. Be free from all forms of abuse.
15. Be told of business ties between the hospital and your other caregivers.
16. Know that the hospital will give you the best care it can. You may be asked to move to another hospital or place of treatment. If so, you will be told your choices and what could happen with those choices.
17. Say yes or no to being a part of research.
18. Be told about how to continue your care upon your discharge from the hospital.
19. Be told of the hospital's rules.
20. Receive a copy of your bill.
21. Be told of how and to whom you may voice a complaint.
22. To receive visitors and have a "support person" designated by you and the right to withdraw or deny consent at any time.
23. Have your cultural, personal values, beliefs, and preferences respected.
24. Right to religious and other spiritual services.

You are Responsible For:

1. Letting the hospital know about any medicines you are taking at home, your medical history and your present medical problems. You should tell the doctors or nurses about any changes to your medical problems while you are in the hospital. This includes telling your doctors or nurses you are in pain and any other information that facilitates care, treatment and service.
2. Giving the hospital a copy of your advance directive, if you have one.
3. Asking questions when you or your family do not understand what you have been told about your medical condition, your treatment or what you should do to care for yourself.
4. Following instructions, including your plan of care as developed by your health care team. Your plan of care includes the effect of lifestyle on your health. You are responsible for accepting the consequences of not getting treatment or not following the instructions of your caregivers.
5. Showing respect for other patients and the hospital staff. This includes treating hospital belongings with respect.
6. Paying your hospital bill. This includes giving the hospital correct information about your insurance or how you intend to pay your bill.

The rights and responsibilities can and should be exercised on the patient's behalf by a parent, guardian, designated surrogate, or proxy decision-maker if the patient lacks decision-making capacity, is legally incompetent or is a minor.

Important Notices

Section 504 Notice Program Accessibility

Coosa Valley Medical Center will take such steps as are necessary to ensure that qualified persons with disabilities, including those with impaired sensory or speaking skills, receive effective notice-written material or other communication-concerning benefits or services. Effective notice will cover, for example, consent to treatment, waivers rights, authorization to dispense medical information, handling of professional valuables, financial agreement(s), financial obligations, assignment of insurance benefits, Medicare patient certification and payment requests.

This facility and all of its programs and activities are accessible to and useable by disabled persons, including persons with impaired hearing and vision. Access features include:

- Convenient off-street parking designated specifically for disabled persons.
- Curb cuts and ramps between parking areas and building.
- Level access into first floor level with elevator access to all other floors.
- Accessible offices, meeting rooms, bathrooms, public waiting areas, cafeteria, patient treatment areas, including examining rooms and patient wards.
- Communication aids provided to persons with impaired hearing, vision, speech, or manual skills, without additional charge for such aids. Some of these aids include:
    - Qualified sign language interpreters for the deaf (when needed)
    - Telecommunication device for the deaf (TTY/TDD) is available through Facility Management to connect the caller to the facility for use by hearing or speech impaired patients/clients.
    - Flash Cards, Alphabet boards and other communication boards.

All aids needed to provide this notice will be provided without cost to the person being served.

Non-Discrimination Statement

Coosa Valley Medical Center (CVMC) does not discriminate against any person on the basis of race, color, national origin, disability or age in admission, treatment, or participation in its programs, services and activities. For further information about this policy, please contact Christy Knowles at 256.401.4171, TTY available.

State Relay Numbers: 1-800-548-2546 (TTY/TDD only) and 1-800-548-2547 (Voice only).

Coosa Valley Medical Center is dedicated to providing our community with comprehensive health services that enhance the health and wholeness of each individual we serve through medical and spiritual support while affirming their personal value and dignity.